Your King County Benefits

This collection of booklets describes coverage available to you and your eligible family members under the King County regular employee and part-time Local 587 benefit plans. It also explains how King County administers these plans and your rights and responsibilities under them.

Between printings, benefit information is updated through new hire guides, open enrollment materials and the county website (www.metrokc.gov/finance/benefits). Please refer to these other sources for details on plan changes, coverage options and costs.

This collection is divided into the separate booklets listed below. Each booklet has a table of contents following the title page (except for the Glossary and Resource Directory) to help you find specific items.

If you're unsure about the meaning of terms used in these booklets, refer to the Glossary. If you don't find the information you need here, in your new hire guide, open enrollment materials or on the Web, please contact **Benefits and Retirement Operations** at 206-684-1556 or the plans listed in the Resource Directory.

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Booklet 1

Important Facts

Although these benefit descriptions include certain key features and brief summaries of King County regular employee and part-time Local 587 benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

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How to Use This Booklet

This booklet explains how your benefit plans are administered and describes what to do when your family or work situation changes. It also includes information regarding your rights and responsibilities, plus required legal notices. To get a more complete understanding of each benefit, review this booklet along with the specific plan booklet. Together they will give you the details you need to use your plans effectively. If you have questions that are not answered here, you'll find phone numbers and websites for further information in the Resource Directory.

Remember, your best and most current source of information is King County's website – things change quickly and printed materials, such as this booklet, can't keep pace as well as the Web.

This collection of booklets contains general, not exhaustive, information about your plans. Additional details concerning the terms and conditions of coverage for the life, accidental death and dismemberment and long term disability plans are contained in policies and certificates filed with the State of Washington. Copies of the certificates are available from Benefits and Retirement Operations. Additional details concerning the terms and conditions of coverage for all other plans are available from Benefits and Retirement Operations (see Resource Directory booklet).

Benefit Eligibility

► Benefit Eligibility If You're a Regular Employee

If you're in a part-time regular (except part-time Local 587), full-time regular, provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible), you're eligible:

- For county-paid medical, dental and vision coverage for you and the eligible family members you enroll
- For county-paid basic life, basic accidental death and dismemberment (AD&D) and basic long term disability (LTD) insurance for yourself
- To purchase enhanced life and enhanced AD&D for yourself and eligible family members, plus enhanced LTD for yourself.

If you and your spouse/domestic partner are both county employees, you may not be covered as both an employee and a dependent at the same time under enhanced life and enhanced AD&D, and only one of you may cover your children for enhanced life and enhanced AD&D.

You're also eligible to participate in other county benefit plans:

- You may set aside pretax dollars from your paycheck in a Health Care Flexible Spending Account (FSA) to pay for certain expenses not covered by your medical, dental and vision plans (see Flexible Spending Accounts booklet)
- You may set aside pretax dollars from your paycheck in a Dependent Care FSA to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent (see Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID and access to Making Life Easier Program services (free and confidential counseling, home mortgage assistance, child and elder care referral and mildly sick child care)
- You may participate in the King County Employees Deferred Compensation Plan and other programs as described in the Other Benefits guide provided at New Employee Orientation.

You're not eligible for these benefits if you work less than half time or are a temporary or seasonal employee, or if you work in a capacity that, at the discretion of Human Resources, is considered contract labor or independent contracting. If you're not treated as a common law employee by King County for income tax withholding (regardless of any later determination of legal employment status), you're not benefit eligible.

► Benefit Eligibility and Cost If You're a Part-Time Local 587 Employee

If you're a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of three benefit plans – Plan 1, Plan 2 or Plan 3.

You're also eligible to participate in other county benefit plans:

- You may set aside pretax dollars from your paycheck in a Health Care Flexible Spending Account (FSA) to pay for certain expenses not covered by your medical, dental and vision plans (see Flexible Spending Accounts booklet)
- You may set aside pretax dollars from your paycheck in a Dependent Care FSA to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent (see Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID and access to Making Life Easier Program services (free and confidential counseling, home mortgage assistance, child and elder care referral and mildly sick child care)
- You may participate in the King County Employees Deferred Compensation Plan and other programs as described in the Other Benefits guide provided after your qualification date.

Plan 1. You become eligible for coverage the first of the month following your qualification or hire date, whichever is later. Your hire date is determined by your department. If your qualification or hire date is the first of the month, you become eligible the same day.

Under Plan 1, you may purchase health coverage (medical, dental, vision) for yourself and eligible family members (you may cover them under all or any plan you elect for yourself), plus basic life insurance ($20,000) for yourself. Certain restrictions apply:

- You must elect medical coverage to elect dental coverage (if you, as the employee, elect medical and dental coverage for yourself, you may cover a family member for dental only)
- If you don't elect basic life insurance when you're first eligible, or elect and drop it later, you may not add it again.

You pay for Plan 1 benefits through payroll deduction. The monthly cost of benefits is divided in half and deducted from your two regular paychecks each month. (When there are three paychecks in a month, no deductions are taken from the last one.)

You may have the deductions taken before or after federal income and Social Security taxes are withheld. If you have deductions taken after-tax, you do not reduce your taxes, but may drop coverage for yourself or a family member anytime. You may change how your payment deductions are taken (before-tax or after-tax) only during open enrollment.

Before-tax deductions do reduce your taxes. However, IRS restrictions apply:

- Any portion you pay to provide coverage to a domestic partner or domestic partner's children is an after-tax deduction
- You may not drop any coverage until the next open enrollment unless it's due to a qualifying change in status:
  - Death of a family member
  - Divorce, legal separation or dissolution of a domestic partnership
  - Significant change in your spouse's or domestic partner's coverage due to his/her employment
- You must re-enroll for before-tax deductions every year during open enrollment or you default to the after-tax arrangement.

Plan 2. Eligibility for Plan 2 is determined by an agreement between King County Metro Transit and Amalgamated Transit Union Local 587 based on working sufficient hours. Direct any questions regarding eligibility for Plan 2 to your base chief.

You become eligible when you have 338 paid hours in either of two four-month periods:

- November 1-February 28/29 (Plan 2 benefits begin May 1)
- March 1-June 30 (Plan 2 benefits begin September 1).

Plan 2 benefits extend through the end of the calendar year. They continue through the end of the following calendar year if you:

- Have an average of 39 hours or more per pay period in the 26 consecutive pay periods that end with the pay period including July 31 (you must have been employed as a part-time Local 587 employee for at least the most recent six complete pay periods to qualify), or

- Pick assignments averaging four hours or more for the February, June and September shake-ups (you must have picked assignments for all three shake-ups to qualify).

Under Plan 2, you receive county-paid medical, dental and vision coverage for you and the eligible family members you enroll, plus the following basic coverage for yourself: life, accidental death and dismemberment (AD&D), and long term disability (LTD) insurance. When you first enroll under Plan 2, you may also purchase enhanced life and AD&D for yourself and eligible family members, plus enhanced LTD for yourself.

If you and your spouse/domestic partner are both county employees, you may not be covered as both an employee and a dependent at the same time under enhanced life and enhanced AD&D, and only one of you may cover your children for enhanced life and enhanced AD&D.

Plan 3. When you lose eligibility for Plan 2, you become eligible for Plan 3.

Under Plan 3, you continue to receive the same county-paid basic life, AD&D and LTD coverage you had under Plan 2 and may continue enhanced life, AD&D and LTD coverage. If you choose to continue medical, dental and vision coverage for yourself and eligible family members, you pay for the coverage. The rates are the same as Plan 1 coverage.

► Benefit Eligibility for Family Members

Eligible family members include:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership must be filed with Benefits and Retirement Operations)
- Unmarried children of you or your spouse/domestic partner if they are under age 23 (life insurance doesn't cover children under 14 days old) and chiefly dependent on you for support and maintenance (generally, that means you may claim them on your federal tax return). They may be your:
  - Natural children
  - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption)
  - Stepchildren
  - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plans; see below)
- A child 23 or older if the child:
  - Was covered under your plans before age 23, and
  - Is incapacitated due to developmental or physical disability and chiefly dependent on you for support.

For a disabled child, you must submit a Continue Coverage for Disabled Adult Child form to Benefits and Retirement Operations within 30 days of the child's 23rd birthday, and provide proof of the child's continued disability periodically thereafter.

Parents and other relatives who are not members of your immediate family are not eligible for coverage.

Domestic Partners. There is no cost for family member health coverage if you qualify for regular or part-time Local 587 Plan 2 benefits. However, when you cover a domestic partner and domestic partner's children for health benefits (medical, dental, vision), the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

Qualified Medical Child Support Order (QMCSO). In accordance with applicable law, the plans provide medical, dental and vision coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A QMCSO is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- Coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

Benefits and Retirement Operations promptly notifies you and the alternate recipient when a QMCSO is received and explains what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits and Retirement Operations notifies you and the alternate recipient by mail.

Enrolling in the Plans

► Enrolling If You're a Regular Employee

You must submit the benefit enrollment forms included in your Regular Employee New Hire Guide within 30 days of your hire date, or your eligible family members won't be covered and you'll be assigned the following default coverage:

- KingCare Basic Medical
- Dental
- Vision
- Basic life insurance
- Basic AD&D insurance
- Basic LTD insurance.

You have several medical plan choices, and may also opt out of medical coverage and receive an additional $65 in monthly pay taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's health care plan and submit a copy of the other medical plan ID card with your enrollment form. (When you opt out of medical, your other benefits are not affected.)

You may opt out only when you're first eligible for benefits or at open enrollment. Even if you become covered under another medical plan, you must wait until the next open enrollment to opt out of county medical coverage.

If you opt out of medical, you may opt back in before open enrollment if you lose your other medical coverage and return a completed Opt Back In form to Benefits and Retirement Operations within 30 days of losing that coverage (coverage becomes effective the first of the month after your other coverage ends). Otherwise, you must wait until the next open enrollment (coverage becomes effective January 1).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see Resource Directory booklet) within 30 days of when your other benefits begin. Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

If default coverage is assigned:

- **Health Coverage and AD&D.** You must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add eligible family members for coverage
- **Life.** You may not add enhanced life at open enrollment, but you may add it during the year if certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- **LTD.** You receive basic LTD but lose the opportunity to add enhanced LTD later.

► Enrolling If You're a Part-Time Local 587 Employee

You receive enrollment materials for each plan as you become eligible.

If you decide to participate in a Flexible Spending Account, you must submit the FSA Enrollment form available from Benefits and Retirement Operations within 30 days of when you become eligible for Plan 1 or Plan 2 benefits. (You are not eligible to enroll in an FSA when you become eligible for Plan 3). Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

Plan 1. You must submit your enrollment form within 30 days of your eligibility date (sooner if possible). Otherwise, you must wait until the next open enrollment to enroll in Plan 1. (If you don't elect basic life insurance when you are first eligible, you may not add it again.)

Plan 2. You must submit your enrollment form by the deadline indicated in your Plan 2 materials (the materials are mailed to you approximately one month before your Plan 2 eligibility begins). Otherwise, only eligible family members you've previously enrolled in a county medical plan will be covered and you'll receive the following default coverage:

- KingCare Basic Medical (if you've never been enrolled in a county medical plan) or the last county medical plan you were in (if it's still available to you)
- Dental
- Vision
- Basic life insurance
- Basic AD&D insurance
- Basic LTD insurance.

When you become eligible for Plan 2 you may opt out of medical coverage and receive an additional $65 in monthly pay taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's health care plan and submit a copy of the other medical plan ID card with your enrollment form. (When you opt out of medical, your other Plan 2 benefits are not affected.)

You may opt out only when you first enroll for Plan 2 benefits or at open enrollment. Even if you become covered under another medical plan, you must wait until the next open enrollment to opt out of county medical coverage.

If you opt out of medical, you may opt back in before open enrollment if you lose your other medical coverage and return a completed Opt Back In form to Benefits and Retirement Operations within 30 days of losing that coverage (coverage becomes effective the first of the month after your other coverage ends). Otherwise, you must wait until the next open enrollment (coverage becomes effective January 1).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see Resource Directory booklet) within 30 days of when your Plan 2 benefits begin. Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see Flexible Spending Accounts booklet).

If default coverage is assigned:

- **Health Coverage and AD&D.** You must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add eligible family members for coverage
- **Life.** You may not add enhanced life at open enrollment, but you may add it during the year if certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- **LTD.** You receive basic LTD but lose the opportunity to add enhanced LTD later.

Plan 3. You must submit your enrollment form by the deadline indicated in your Plan 3 materials (the materials are mailed to you approximately one month before your Plan 3 eligibility begins). Otherwise, all previous Plan 2

coverage except basic life, basic AD&D and basic LTD for you will end the day before your Plan 3 eligibility begins, and you:

- Must wait until the next open enrollment to add health (medical, dental, vision), elect enhanced AD&D and add eligible family members for coverage (see "Changes You May Make When a Qualifying Event Occurs")
- May not add enhanced life again until certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- May not add enhanced LTD.

When Coverage Begins

► When Coverage Begins If You're a Regular Employee

Coverage begins the first of the month following your hire date, as determined by your department (unless modified by your collective bargaining agreement). If your hire date is the first of the month, your coverage begins the same day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you're first eligible, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- **AD&D.** If you're not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.
- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work day.

► When Coverage Begins If You're a Part-Time Local 587 Employee

Plan 1. If you enroll, coverage begins the first of the month following your qualification or hire date, whichever is later. Your hire date is determined by your department. If your hire date is the first of the month, your coverage begins the same day.

When you first enroll for Plan 1, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year (as long as you remain eligible), unless you qualify for Plan 2 effective May 1 or September 1 (see "Plan 2" information).

Plan 2. Coverage begins January 1, May 1 or September 1, depending on your eligibility date.

When you're first eligible for Plan 2, the start of some coverage may be delayed:

- **Medical.** If you're hospitalized on the day coverage would start, coverage begins after discharge.
- **Life.** If you're not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- **AD&D.** If you're not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.

- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

Plan 3. Coverage begins January 1 and stays in effect for the entire calendar year (as long as you remain eligible), unless you re-qualify for Plan 2 effective May or September 1 (see "Plan 2" information).

► When Coverage Begins for Eligible Family Members

Coverage for the eligible family members you list on your enrollment form begins when your coverage begins, with the exceptions listed below. If you don't enroll eligible family members when you enroll, you must wait until the next open enrollment or a qualifying change in status to add them for coverage (see "Changes You May Make When a Qualifying Event Occurs" in this booklet).

For eligible family members added due to a qualifying change in status, health coverage (medical, dental and vision) for your:
- Newborn or newly adopted child is retroactive to the date of birth or placement
- Child (other than a newborn or adopted) begins the first of the month following the event that qualified him/her to be added; if the event occurs on the first of the month, coverage begins the same day
- New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership; if you marry or establish your domestic partnership on the first of the month, coverage begins the same day.

Coverage under all medical plans is provided for newborns under the mother's benefits for the first three weeks of life. To continue the newborn's coverage after that, the newborn must be eligible and enrolled within 60 days of birth.

Generally, if you elect enhanced life and AD&D for your eligible family members, their coverage begins the first of the calendar month premium deductions are taken from your paycheck. In some cases, however, the start of coverage may be delayed:
- **Life.** Children younger than 14 days are not eligible for life insurance, so coverage does not begin until the 14th day.
- **AD&D.** If they're confined in a hospital or other facility at the time coverage would typically begin, coverage begins on the first day of the month following discharge (except for newborns).

Making Changes: General Information

The next four sections describe how to make changes to your benefit coverage between first enrolling and leaving county employment. Your change may require supporting documentation and one or more of these forms:
- Add New Family Member
- Affidavit of Marriage/Domestic Partnership
- Beneficiary Designation
- Continue Coverage for Disabled Adult Child
- Delete Family Member
- Enhanced Life/AD&D Change
- Flexible Spending Account Enrollment
- Opt Back In
- Personal Information Update.

All forms are available at www.metrokc.gov/finance/benefits or from Benefits and Retirement Operations (see the Resource Directory booklet).

You Must Drop Ineligible Family Members

You must drop family members from coverage when they are no longer eligible (see "Benefit Eligibility for Family Members" in this booklet). To drop ineligible family members, submit a Delete Family Member Form to Benefits and Retirement Operations within 30 days of the date they become ineligible. The date a family member becomes ineligible is reported to the carriers and any expenses incurred after that date are your responsibility.

Benefits and Retirement Operations must receive the form by the fifth of the month to stop payroll deductions for any premiums you pay that month.

When you drop ineligible family members:
- They may continue health coverage under COBRA or individual self-paid insurance (when you divorce and the divorce decree states you must provide health insurance for your ex-spouse, you must drop your ex-spouse from county-paid coverage and continue coverage through COBRA or individual self-paid insurance)
- You may add them back to your coverage if and when they become eligible again.

Changes You May Make Anytime

You May Drop Eligible Family Members from Coverage

You may drop eligible family members from coverage anytime – except for health coverage you pay for through before-tax payroll deduction (part-time Local 587 Plan 1 or 3). If you pay for their health coverage through before-tax payroll deduction, you may drop family members only when a relevant qualifying change in status occurs – for example, you divorce/end a domestic partnership, a family member dies, a child is no longer a dependent, a Qualified Medical Child Support Order ends or a family member becomes eligible for his/her own benefit plan. If you do not have a relevant qualifying change in status, you must wait until the next open enrollment.

To drop a family member, submit a Delete Family Member form. Benefits and Retirement Operations must receive the form by the fifth of the month to stop payroll deductions for any premiums you pay that month for coverage. The date a family member is dropped is reported to the carriers and any expenses incurred after that date are your responsibility.

When you voluntarily drop family members, you may not add them back again:
- For health coverage (medical, dental and vision), until the next open enrollment or a qualifying change in status occurs (see "Changes You May Make When a Qualifying Event Occurs")
- For life insurance, except for certain qualifying events (see "Changing Enhanced Life/AD&D Coverage")
- For AD&D, until the next open enrollment or a qualifying change in status occurs (see "Changing Enhanced Life/AD&D Coverage").

You May Drop or Reduce Self-Paid Coverage

You may drop or reduce any coverage you pay for anytime – except for health coverage you pay for through before-tax payroll deduction (part-time Local 587 Plan 1 or 3). If you pay for health coverage through before-tax payroll deduction , you may drop coverage only when a relevant qualifying change in status occurs – for example, you become eligible for other health coverage. If you do not have a relevant qualifying change in status, you must wait until the next open enrollment.

To drop or reduce coverage, submit a detailed written or email request (no form is available). Benefits and Retirement Operations must receive your request by the fifth of the month to stop or reduce payroll deductions for any premiums you pay that month for coverage. The date coverage is dropped is reported to the carriers and any expenses incurred after that date are your responsibility.

If you:

- Drop health coverage (medical, dental or vision coverage under part-time Local 587 Plan 1 or 3), you may not add it again until the next open enrollment or you subsequently lose the coverage that qualified you to drop your self-paid county coverage (see "You May Request Health Coverage Previously Declined/Opted Out" in the next section)
- Drop basic life (part-time Local 587 Plan 1 only), you may not add it again
- Drop or reduce enhanced life, you may add or increase it again only when certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Drop or reduce enhanced AD&D, you may add or increase it again only during open enrollment
- Drop enhanced LTD, you may not add it again.

Changes You May Make When a Qualifying Event Occurs

► You May Add Eligible Family Members for Health Coverage

Except for birth or placement for adoption, you must submit an Add New Family Member form within 30 days of these qualifying events (sooner if possible) to add an eligible family member for health coverage (medical, dental, vision):

- Placement of a legal ward
- Marriage or establishment of a domestic partnership
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

If you do not submit the form within 30 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Birth or Placement for Adoption. A newborn is automatically covered under the mother's coverage for the first three weeks. You have 60 days to add a newborn or a newly adopted child for health coverage, but because you have only 30 days to make changes to enhanced life/AD&D coverage, it's highly recommended you submit all forms within 30 days of birth or placement for adoption to take advantage of your life/AD&D change options.

If you do not submit the form within 60 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Qualified Medical Child Support Order. When Benefits and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document (you do not need to submit an Add New Family Member form).

► You May Change Enhanced Life/AD&D Coverage

You must submit an Enhanced Life/AD&D Change form within 30 days of a qualifying event to change your enhanced life and AD&D coverage.

Enhanced Life. You may add or increase enhanced life insurance for yourself and add a:

- Spouse/domestic partner for enhanced life when he/she:
  - Becomes your new spouse/domestic partner (if you do not elect enhanced life for your domestic partner when he/she is first eligible, you may not elect the coverage if he/she becomes your spouse; future marriage to the same person is not a qualifying event), or
  - Loses his/her own county or other employer-provided coverage
- Child when he/she:
  - First becomes eligible
  - Loses county or other employer-provided coverage under a spouse/domestic partner's coverage.

If you don't submit the form within 30 days, you may not add the family member for enhanced life again, with one exception: when you add one child during a qualified family status change for enhanced life, the coverage is

automatically extended to all eligible dependent children enrolled under your benefit plans, including children previously not covered or dropped from enhanced life coverage.

Enhanced AD&D. If you have enhanced AD&D coverage for yourself, you may add a:

- Spouse/domestic partner for enhanced AD&D when he/she:
  - Becomes your new spouse/domestic partner (if you do not elect enhanced AD&D for your domestic partner when he/she is first eligible, you may not elect the coverage if he/she becomes your spouse; future marriage to the same person is not a qualifying event), or
  - Loses his/her own county or other employer-provided coverage
- Child when he/she:
  - First becomes eligible
  - Loses county or other employer-provided coverage under a spouse/domestic partner's coverage.

If you don't submit the form within 30 days, you may not add the eligible family member for enhanced AD&D until the next open enrollment, with one exception: when you add one child for enhanced AD&D between open enrollments, the coverage is automatically extended to all eligible dependent children enrolled under your benefit plans, including children previously not covered or dropped from enhanced AD&D coverage.

► You May Request Health Coverage Previously Declined/Opted Out

You must submit an Opt Back In form within 30 days of losing other coverage (sooner if possible) if you or a family member loses health coverage through another employer and wishes to opt back in under county plans. If you don't submit the form within 30 days, you may not opt back in under county plans until the next open enrollment.

If your other coverage is COBRA (and you declined county coverage when you first became eligible for any county plan), COBRA must be exhausted before you can opt in to coverage outside of open enrollment. For other than COBRA coverage, the loss of coverage must be due to divorce, legal separation, death, termination of employment, reduction of hours or termination of employer contributions toward the other coverage.

► You May Request Continuation of Coverage for a Disabled Adult Child

You may continue coverage for a child past age 23 if the child is covered under your plans, is incapacitated due to developmental or physical disability and is chiefly dependent on you for support. To do so, submit a Continue Coverage for Disabled Adult Child form six months before the child turns 23 or no later than 30 days after.

Changes You May Make at Open Enrollment

Open enrollment every October lets you make the following changes in coverage without qualifying changes in status:

- Change medical plans
- Add eligible family members
- Add or increase enhanced AD&D for yourself and eligible family members
- Enroll/reenroll in an FSA (you must reenroll each year to continue participating).

Changes you make at open enrollment become effective January 1 of the next year. However, if you drop family members from coverage who are no longer eligible, they are dropped the date they became ineligible, the date is reported to the carriers and any expenses incurred after that date are your responsibility.

When Coverage Ends

► When Coverage Ends for You

Your benefit coverage ends the:
- Last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die, or
- Day the plan terminates.

Certain restrictions apply to AD&D and LTD coverage if you enter military service (see "If You Leave Employment to Perform Uniformed Service").

► When Coverage Ends for Family Members

Family member benefit coverage ends the:
- Last day of the month they lose eligibility, your coverage ends, you fail to make any required payments for their coverage or they die, or
- Day the plan terminates.

Certain restrictions apply to life and AD&D coverage if a covered family member enters military service (see "If You Leave Employment to Perform Uniformed Service"). Also, AD&D coverage for a spouse/domestic partner automatically ends when the spouse/domestic partner reaches age 80.

Family-Medical Leave

► Family-Medical Leave Eligibility

If you've worked for King County at least a year (need not be 12 consecutive months) and have worked 1,040 hours (if you're scheduled to work 40 hours a week), 910 hours (if you're scheduled to work 35 hours a week) or 510 hours (if you're a part-time Local 587 employee) during the 12 months immediately preceding your leave request, you're eligible to take job-protected leave for certain family and medical reasons. Hours counted toward eligibility must be hours actually worked – vacation and sick leave hours do not count.

Under the federal Family and Medical Leave Act (FMLA), you're eligible for up to 12 weeks of leave in a rolling 12-month period, starting with any paid leave you have available and continuing as unpaid leave when your paid leave runs out. Under King County Family and Medical Leave (KCFML), you're eligible for up to 18 weeks of unpaid leave, including any unpaid leave you took under FMLA. However, if you've taken FMLA leave/KCFML during the 12 months immediately preceding your latest request, your maximum allotment is reduced by that amount.

FMLA applies to all county employees. KCFML applies to all nonrepresented employees and represented employees whose unions have agreed to the terms of KCFML (refer to your union contract). If you have questions about FMLA and KCFML eligibility, talk to your supervisor, department's human resources staff or union representative, or contact Benefits and Retirement Operations (see Resource Directory booklet).

► Reasons for Taking Family-Medical Leave

You may take leave for these reasons:
- A serious health condition that makes you unable to perform your job
- Birth of a child
- Caring for your child after birth, adoption or placement for adoption or foster care
- Caring for your spouse with a serious health condition
- Caring for your or your spouse's son, daughter or parent with a serious health condition.

King County also allows FMLA benefits while caring for a domestic partner or domestic partner's son, daughter or parent with a serious health condition.

A serious health condition is an illness, injury, impairment or physical or mental condition that involves one or more of the following:

- An acute episode that requires more than three consecutive calendar days of incapacity and at least one follow-up treatment by a health care provider
- A chronic ailment continuing over an extended time that requires periodic visits by a health care provider and causes continuous or intermittent episodes of incapacity
- Inpatient care in a hospital, hospice or residential medical care facility
- An ailment requiring multiple interventions or treatment by a health care provider
- Any period of incapacity due to pregnancy or prenatal care.

► Advance Notice and Medical Certification for Family-Medical Leave

You must submit your leave request 30 days in advance when your leave is foreseeable or as soon as possible when your leave is not foreseeable.

You also must provide medical certification to support a leave request because of a serious health condition. And if requested, you'll need to submit second or third opinions (at King County's expense) as well as a fitness for duty report to return to work.

► Use of Sick and Vacation Leave for Family-Medical Leave

You must use all your sick leave for your own serious health condition (unless the condition is due to an on-the-job injury). After sick leave is exhausted, you may use vacation and other paid leave if approved.

To care for a family member, you may use sick leave or, if approved, vacation leave. If you use sick leave, you may reserve up to 80 hours of it for your own future use.

You may use donated sick and donated vacation leave for family-medical leave, but if you do, you must use all your own sick leave before using donated sick leave and all your own vacation leave before using donated vacation leave.

► When Family-Medical Leave Begins

FMLA leave begins the first day you are off the job. KCFML begins the first day you're no longer being paid from your own sick leave, vacation or other paid leave accruals. (In most cases, for an on-the-job injury, you may opt to go to unpaid leave status and begin KCFML immediately; refer to your union contract.)

Leave may be taken on a reduced or intermittent work schedule if approved by your supervisor.

► Continuation of Benefits under Family-Medical Leave

Under FMLA leave or KCFML, county-paid medical, dental and vision benefits continue while you're on leave. If you go on unpaid leave status, you may pay the full premium to continue your life insurance for up to 12 months, AD&D for up to six months and LTD for up to 18 weeks. Benefits and Retirement Operations will contact you regarding continuation of benefits when it receives your approved leave request.

► Job Protection under Family-Medical Leave

Upon return from FMLA leave or KCFML, you are restored to your original or equivalent position with equivalent pay, benefits, seniority and other employment terms. You won't lose any employment benefits that accrued before your leave began. No adverse personnel actions may be taken against you for taking FMLA leave or KCFML.

Your job is protected while on FMLA/KCFML. However, you may lose your job protection if you fail to return to work by the expiration date of your approved family-medical leave. Failure to return by the expiration date may be cause for removal and result in termination of your employment.

King County may not interfere with, restrain or deny the exercise of any right provided under FMLA. The county may not discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. The US Department of Labor is authorized to investigate and resolve complaints of violations, and an FMLA-eligible employee may bring a civil action against King County for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Leave of Absence without Pay

If you do not qualify for leave under FMLA or KCFML, your benefit coverage for medical, dental and vision:

- Continues uninterrupted if your unpaid leave is less than 31 days
- May be continued under COBRA if your unpaid leave is 31 days or more (county coverage ends the last day of the month you work before the leave begins).

If you are on leave past your FMLA/KCFML period on unpaid status, your benefit coverage may be continued under COBRA.

If You Become Disabled

► Accommodation Policy If You Become Disabled

Under federal (American with Disabilities Act), state and local laws, King County provides reasonable accommodations for you if you are disabled, regardless of how or when you become disabled, or whether the disability is permanent or temporary. Disabilities may be caused by injury, accident or disease, or may have been present since birth.

► What to Do If You Become Disabled

If you become disabled:

- File a workers' compensation claim with Safety & Claims Management if the disability is work related
- Contact the Disability Services Program (Local 587 employees contact Metro Transit Human Resources)
- Apply for family-medical leave (FMLA/KCFML) with your supervisor if your disability keeps you from working
- File a claim for LTD benefits with CIGNA if you have them and you're going to be off work beyond your waiting period (you must provide proof of your disability within 12 months after your disability begins and then annually, or your claim may be denied; you must continue to pay the premium during your waiting period; see the CIGNA Long Term Disability Insurance booklet)
- Contact Benefits and Retirement Operations about continuing your life insurance and Health Care Flexible Spending Account (see appropriate plan booklets)
- Contact the Washington State Department of Retirement Systems to discuss benefit options if your disability keeps you from working
- Contact T. Rowe Price, King County's deferred compensation plan administrator, if you are a participant and your disability has created an unforeseen financial hardship (you may qualify for a hardship withdrawal)
- Apply for Social Security disability income if your disability qualifies.

See the Resource Directory booklet for contact details.

► Continuation of Health Benefits If You Become Disabled

Under Family-Medical Leave. If your disability qualifies you for leave under FMLA, KCFML or both, your health coverage (medical, dental, vision) continues for the length of the leave.

Under Leave of Absence without Pay. If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML period on unpaid status, your health coverage ends. You may be eligible to pay to continue coverage under COBRA (see "COBRA" in this booklet).

If you or covered family members in the KingCare Basic or Preferred medical plans are totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this medical extension or COBRA coverage, but electing the extension means they forfeit the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA.

Medical extension coverage will end on the date coverage terminates for the group you were in when you became disabled or on the date you or your family members experience any of the following:
- Reach any lifetime maximum
- Are no longer disabled
- Become eligible for benefits under another group policy
- Reach the end of the 12-month extension.

If you or covered family members in the Group Health medical plan become disabled, your coverage ends. You may be eligible to continue coverage under a family-medical leave and then under COBRA.

► Continuation of Life Insurance If You Become Disabled

If you notify Benefits and Retirement Operations within 30 days of when you become disabled, your coverage may be continued for up to 12 months or longer. See the Aetna Life Insurance booklet for details.

► Continuation of AD&D Insurance If You Become Disabled

If you're disabled and notify Benefits and Retirement Operations within 30 days of your disability, your basic AD&D continues at no cost to you for up to six months after the disability occurs. If you're not disabled and not terminated from county employment, you may self-pay to continue your enhanced AD&D for up to six months while on an approved leave of absence.

► Continuation of LTD If You Become Disabled

If your leave is due to your own disability and continues beyond the FMLA/KCFML period, you may continue to pay the premiums through the remainder of your LTD benefit waiting period. While you're receiving LTD benefits, you will not be responsible for monthly premiums.

► Job Reassignment and Search Assistance If You Become Disabled

If you cannot be accommodated in your regular job and are separated from your position, employment placement assistance is provided through the Disability Services Program in two phases, lasting up to nine months. The program will help you:
- Be reassigned through a non-competitive hiring process during the first four months
- Find and apply to posted job positions as an internal candidate for an additional five months if reassignment is unsuccessful.

COBRA

► COBRA Eligibility

If you or your qualified family members lose county-paid health coverage due to certain events, each of you has an independent right to self-pay under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for health coverage (medical, dental, vision). This coverage may continue for 18 to 36 months after county-paid coverage ends (the last day of the month the qualifying event occurs). Length of the COBRA continuation coverage period depends on the event:

- Termination of employment if for reasons other than gross misconduct – 18 months
- Layoff – 18 months
- Reduction in work hours/no longer eligible for county-paid benefits – 18 months
- Disability – 29 months if you or family members are determined Social Security disabled at the time of or within 60 days of when COBRA eligibility begins; the COBRA participant must provide a copy of the Social Security disability determination to AAI, King County's COBRA administrator, before the end of the first 18 months of COBRA coverage and within 60 days after being determined disabled under Social Security)
- Death – 36 months for surviving qualified family members
- Divorce/dissolution of domestic partnership – 36 months for qualified family members
- Dependent child ceases to be a dependent (may no longer be claimed as an IRS dependent or reaches age 23) – 36 months for child
- Medicare entitlement – 36 months for qualified family members.

If a second qualifying event occurs during an 18- or 29-month COBRA continuation coverage period, coverage may be continued for eligible family members for up to 36 months from the first qualifying event, but the total COBRA continuation coverage period will not exceed 36 months.

You and your qualified family members may elect coverage even if covered under another employer-sponsored health plan or entitled to Medicare at the time you elect coverage.

If you are participating in a Health Care Flexible Spending Account when you become eligible for COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► COBRA Enrollment

COBRA-qualifying events (other than divorce, dissolution of a domestic partnership or child reaching age 23) are reported to Benefits and Retirement Operations through your termination notice or payroll report. For family members who lose coverage through you because of divorce, dissolution of a domestic partnership or child reaching age 23, you must notify Benefits and Retirement Operations within 60 days of the last of the month the qualifying event occurs or the date coverage ends, if later. Otherwise, the family member will not be offered the option to elect COBRA continuation coverage (see "Dropping Family Members from Coverage" in this booklet).

When COBRA-qualifying information is received, Benefits and Retirement Operations notifies Associated Administrators Inc. (King County's COBRA benefits administrator), who contacts you/family members regarding benefit plan options.

You have 60 days after coverage ends to make your COBRA elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect COBRA continuation coverage, you must make the initial payment by the 45th day after electing it. Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days. AAI will give you payment information.

Once you have elected COBRA and paid the premium, COBRA continuation coverage is retroactive. There is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► COBRA Options

Your COBRA options will be explained in the enrollment information you receive from AAI. COBRA allows you to self-pay to continue all the health coverage (medical, dental and vision) you have on your last day of employment or one of these options (if you qualify):

- Medical only (as long as medical was included as part of your health coverage on your last day)
- Medical and vision (if you had medical and vision but no dental on your last day)
- Dental and vision (if you had dental and vision but no medical on your last day)
- Vision only (if vision is the only coverage you had on your last day).

You may continue covering the same family members who were covered the last day of your employment or you may drop any of them from coverage anytime. If you drop family members from coverage, they have their own COBRA rights. However, family members added after you elect COBRA coverage do not have separate COBRA rights (except for newborns and newly adopted children of the employee).

Life. It is not a provision of COBRA, but if you end employment with the county (not if you retire or leave employment due to a disability), you may be eligible to continue your coverage through the portability feature of the policy (see the Aetna Life Insurance booklet for additional details on portability or converting your coverage).

► Making Changes under COBRA

If you notify AAI (King County's COBRA administrator), you may:

- Drop dental and vision and retain medical coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Change medical plans during open enrollment
- Change medical plans between open enrollments if you move out of your current plan's coverage area and provide proof of your new permanent address, and another King County plan offers coverage in your new location.

► When COBRA Coverage Ends

COBRA coverage ends the:

- Last day of the month you or your family member fails to make the required payments within 30 days of the due date, becomes entitled to Medicare benefits after electing COBRA, reaches the end of your maximum COBRA coverage period or is no longer disabled as determined by Social Security and has exhausted designated months of COBRA coverage
- Day the plan terminates or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage)

If you die, your covered family members may extend their COBRA coverage up to 36 months from the date their COBRA coverage started.

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your COBRA continuation coverage will be terminated.

- You do not have to show you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are no longer covered under the county's plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

Retiree Benefits

► Retiree Benefit Eligibility

County-paid coverage ends the last of the month you retire. You may self-pay to continue medical and vision coverage (but not dental) if you:

- Have county benefits on your last day of employment
- Have worked for King County for at least five consecutive years before you retire
- Are not eligible for Medicare
- Are not covered under another medical group plan
- Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Dental, life, AD&D and LTD coverage is not available under retiree benefits.

Retiree benefits are an alternative to COBRA; if you elect retiree benefits, you waive your COBRA rights. Consider these differences in choosing between retiree and COBRA benefits:

	Retiree Benefits	COBRA
Health coverage available	Medical and vision	Medical, dental and vision
Length of time coverage is available	Until you become eligible for Medicare	18 months maximum (29 months if you leave employment due to a disability as determined by Social Security)
Allowed to change medical plans between open enrollments	No	Yes, if you relocate out of your current plan's coverage area and notify AAI with proof of your new permanent address and availability of coverage under another King County plan in your new location

If you are participating in a Health Care Flexible Spending Account when you become eligible for retiree benefits or COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► Retiree Benefit Enrollment

Your retirement is reported to Benefits and Retirement Operations through your termination notice or payroll report. Benefits and Retirement Operations then notifies Associated Administrators Inc. (King County's retiree benefit administrator), who contacts you regarding benefit plan options.

You have 60 days after coverage ends to make retiree elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect retiree benefits, you must make the initial premium payment by the 45th day after your election. Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days after the payment due date. AAI will give you payment information.

Because retiree benefit coverage is retroactive, there is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► Retiree Benefit Options

If you elect retiree benefits, you self-pay to continue the same health coverage you had on your last day of employment. Your options for retiree coverage include:

- Medical and vision
- Medical only.

When you elect retiree benefits, you may continue covering the same family members who were covered the last day of your employment. If you do not continue covering the same family members, they have their own COBRA rights. If you continue covering the same family members under your retiree benefits and they cease to be eligible for retiree benefits, your family members have COBRA rights only if there is a qualifying event (see "COBRA" in this booklet).

► Making Changes under Retiree Benefits

If you notify AAI, you may:

- Drop vision and retain medical coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs" in this booklet)
- Change medical plans during open enrollment.

► When Retiree Benefit Coverage Ends

Retiree benefits end the:

- Last day of the month you fail to make the required payments within 30 days of the due date or become entitled to Medicare after electing retiree benefits, or
- Day the plan terminates, you die or you first become covered under another group health plan after the date of your retiree benefit election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

Federal laws restrict the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your retiree coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your retiree coverage will end.
- You do not have to show you are insurable to choose retiree coverage. However, retiree benefits are subject to your eligibility for coverage; King County reserves the right to end your coverage retroactively if you are determined ineligible.

► If You Return to Work in a Benefit-Eligible Position

Your Washington State Department of Retirement Systems plan may allow you to return to work at King County after you retire while continuing to draw your pension benefits (certain restrictions apply; contact the Department at the number in the Resource Directory booklet).

If you return from retirement to work in a benefit-eligible position, you receive the same coverage a regular or part-time Local 587 employee in the position receives. During this return-to-work period, the premiums you pay for retiree benefits are suspended. When the work period ends, you have the option of resuming your retiree benefits. If you return as a part-time Local 587 employee in Plan 1 you must pay a portion of monthly premiums.

Anytime you fail to meet eligibility requirements (for instance, you don't work the required number of hours in a month) or when you leave post-retirement employment, you resume paying the full cost of your retiree benefits. You must contact AAI to resume your retiree benefits.

If You Leave Employment to Perform Uniformed Service

You need to provide your supervisor, personnel representative and Benefits and Retirement Operations with written notice and a copy of your orders both when you leave employment to perform uniformed service (such as in the military) and when you return to employment after uniformed service. While performing uniformed service your benefit coverage may be continued, depending on the circumstances.

If you leave employment to serve in the military or are called to active duty, you may be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and King County Ordinance 13377. Call Benefits and Retirement Operations for more information.

If You're on a Mutual Aid Assignment

Occasionally, for instance in the case of a natural disaster, you may be asked to work temporarily for another agency in need of extra help. If you need health care while you're working in this situation, you will not pay more for the care because you're outside your usual area. Submit claims directly to the Manager of Benefits and Retirement Operations for processing and payment.

If you are on loan to a Borrower under the Northwest Mutual Aid Group Omnibus Agreement, you will continue to be covered under your regular medical, dental and vision plan. If, as a result of this arrangement, you receive services outside of the normal network area covered by your plan, your care will be covered by the county at the network level.

If You Enter Into a Labor Dispute

If you enter into a labor dispute, your King County coverage ends. If your pay is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, you may be able to continue your benefit coverage temporarily by paying the full cost through COBRA:

- Medical, dental and vision coverage for up to 18 months (you may also continue participating in a Health Care FSA by contributing on an after-tax basis; see the Flexible Spending Accounts booklet)
- Life insurance for up to 12 months
- AD&D coverage for up to six months.

It may be possible to continue benefit coverage longer than indicated above if you convert from county group coverage to an individual plan. Check with each plan (see the Resource Directory booklet) for details.

If You or a Covered Family Member Dies

► If You Die

If you die while a participant in King County benefit plans, your family/beneficiaries must provide a death certificate to Benefits and Retirement Operations. When that occurs, Benefits and Retirement Operations will assist your family/beneficiaries with:

- Completing a claim for any life insurance, accidental death insurance or disability survivor benefit they're entitled to receive (see the respective plan booklets; if death is due to accident, the accident report is required)
- Understanding COBRA and options for continuing the health coverage they had through you
- Submitting claims for reimbursement under an FSA if you were enrolled
- Contacting the:
  - King County Employees Deferred Compensation Plan coordinator
  - Washington State Department of Retirement Systems
- Receiving the final paycheck
- Counseling and referral through the Making Life Easier Program.

► If a Family Member Dies

If your family member dies while you are a participant in King County benefit plans, contact Benefits and Retirement Operations for assistance with:
- Completing a claim for any life or accidental death insurance benefit you're entitled to receive (death certificate is required; if death is due to accident, accident report is also required)
- Completing other benefit forms as required
- Making benefit changes as appropriate
- Counseling and referral through the Making Life Easier Program.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. In general, they cannot be assigned (or given away) to another person and are not subject to attachment or garnishment. However, there are exceptions; for details contact Benefits and Retirement Operations.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. This means the plans are not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promises in writing to:
- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the applicable plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred
- Cooperate fully with the plans in asserting their rights by supplying all information and executing all documents reasonably needed for that purpose.

Any sums collected by or for you or your covered family members by legal action, settlement or otherwise on account of these benefits are payable to the plans only after and to the extent they exceed the amount required to fully compensate your loss.

This provision does not apply to life, accidental death and dismemberment, and long term disability.

Recovery of Overpayments

The plans have the right to recover amounts they paid that exceed the amount for which they are liable. These amounts may be recovered from one or more of the following (to be determined by the plans):

- Persons to or for whom the payments were made
- Other insurers
- Service plans
- Organizations or other plans.

These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plans' right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

The LTD plan has a separate overpayment reimbursement policy and process (see the plan certificate for details).

Termination and Amendment of the Plans

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plans for any reason at any time. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

LTD. Your right to receive LTD benefits for a period of disability that begins while you're covered will not be affected by plan amendment or termination, or termination of your coverage.

Your Patient Rights

► Dignity and Respect under Your Health Plans

You have the right to:

- Be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.
- See your own health records and to have those records kept private and confidential unless required to settle a claim, for plan operations, payment of claims, and as required by law.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

► Knowledge and Information Concerning Your Health Plans

You have the right – and the responsibility – to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Your health condition and status
- Services and procedures involved in your treatment
- Ongoing health care you need once you're discharged or leave the provider's office
- How the plans work (see the appropriate plan booklets)
- Any medication prescribed for you – what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your provider otherwise.

► Continuous Improvement of Your Health Plans

You have the right to:
- Call or write with any questions or concerns and make suggestions for improving the plans
- Ask your providers to explain or give you more information about any health advice or prescribed treatment
- Appeal any health care or administrative decisions (see "Appealing a Claim" in the individual plan booklets).

► Privacy Protection

To protect your privacy, King County and your plans will use only the last four digits of your Social Security number (or no number at all) or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

► Medical Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:
- Refuse treatment – as long as you accept the responsibility and consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for care
- Refuse to take part in any health care research projects
- Be advised on the full range of treatment options (whether covered under the plans or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You're also responsible to:
- Identify yourself and covered family members to providers when you receive services by showing your plan ID card (if provided by your plan) or providing your complete Social Security numbers (or unique identifier numbers if issued by the plan)
- Give your current provider all previous and relevant health care records and submit accurate, complete health information to all physicians or other providers involved in your care
- Be on time for appointments and let your provider's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let your medical plan and primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care
- Tell the plan and your primary care provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay
- Pay all required copayments when you receive health care.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.